		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040923

Facility Name: Lexington of Wheeling

Address: 730 W. Hintz Road (Number) Wheeling (City) 60090 (Zip Code)

County: Cook

Telephone Number: (847) 537-7474 **Fax #** (847) 537-7599

IDPA ID Number: 363885225001

Date of Initial License for Current Owners: 05/12/95

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	221	Skilled (SNF)	221	80,665	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	221	TOTALS	221	80,665	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,901	5,298	6,989	43,188	8
9	SNF/PED					9
10	ICF	14,851	1,553	629	17,033	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,752	6,851	7,618	60,221	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.66%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/12/95

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New Construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 4,597

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	285,554	42,999	11,224	339,777		339,777		339,777			1
2	Food Purchase		272,104		272,104		272,104	(12,552)	259,552			2
3	Housekeeping	262,003	33,061		295,064		295,064	385	295,449			3
4	Laundry	64,345	19,309		83,654		83,654	(2,756)	80,898			4
5	Heat and Other Utilities			150,611	150,611		150,611	3,859	154,470			5
6	Maintenance	70,203		107,508	177,711		177,711	2,455	180,166			6
7	Other (specify):*											7
8	**TOTAL General Services**	682,105	367,473	269,343	1,318,921		1,318,921	(8,609)	1,310,312			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,248,640	185,437	74,691	3,508,768		3,508,768		3,508,768			10
10a	Therapy			600,166	600,166		600,166		600,166			10a
11	Activities	174,871	13,865	6,709	195,445		195,445		195,445			11
12	Social Services	58,013		2,202	60,215		60,215		60,215			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,481,524	199,302	707,768	4,388,594		4,388,594		4,388,594			16
	C. General Administration											
17	Administrative	168,275		359,586	527,861		527,861	(359,586)	168,275			17
18	Directors Fees											18
19	Professional Services			59,803	59,803		59,803	(1,173)	58,630			19
20	Dues, Fees, Subscriptions & Promotions			38,886	38,886		38,886	844	39,730			20
21	Clerical & General Office Expenses	530,564	36,651	22,699	589,914		589,914	23,915	613,829			21
22	Employee Benefits & Payroll Taxes			666,391	666,391		666,391	80,120	746,511			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,836	3,836		3,836	2,929	6,765			24
25	Other Admin. Staff Transportation							9,672	9,672			25
26	Insurance-Prop.Liab.Malpractice			194,825	194,825		194,825	3,787	198,612			26
27	Other (specify):*											27
28	**TOTAL General Administration**	698,839	36,651	1,346,026	2,081,516		2,081,516	(239,492)	1,842,024			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,862,468	603,426	2,323,137	7,789,031		7,789,031	(248,101)	7,540,930			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lexington of Wheeling #0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			29,439	29,439		29,439	237,757	267,196			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,162	16,162		16,162	383,321	399,483			32
33	Real Estate Taxes							454,949	454,949			33
34	Rent-Facility & Grounds			1,645,705	1,645,705		1,645,705	(1,645,705)				34
35	Rent-Equipment & Vehicles			3,221	3,221		3,221	4,199	7,420			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,694,527	1,694,527		1,694,527	(565,479)	1,129,048			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		123,924		123,924		123,924		123,924			39
40	Barber and Beauty Shops			23,462	23,462		23,462		23,462			40
41	Coffee and Gift Shops			1,646	1,646		1,646		1,646			41
42	Provider Participation Fee			120,997	120,997		120,997		120,997			42
43	Other (specify):* **Nonallowable Costs**			59,092	59,092		59,092	(59,092)				43
44	**TOTAL Special Cost Centers**		123,924	205,197	329,121		329,121	(59,092)	270,029			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,862,468	727,350	4,222,861	9,812,679		9,812,679	(872,672)	8,940,007			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(123)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(2,756)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(129)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,070)	43		13
14	Non-Care Related Interest	(6,021)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34,019)	43		24
25	Fund Raising, Advertising and Promotional	(17,915)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule A	(19,066)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (81,099)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(791,573)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (791,573)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (872,672)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923
1/1/03-12/31/03

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Disallow nonallowable collection fees and out of period fees	(12,868)	19
Offset miscellaneous income	(110)	21
Nonallowable personal item replacement	(1,882)	43
Disallow radiology	(2,135)	43
Disallow laboratory	(2,071)	43
Total	(19,066)	

See Accountants' Compilation Report

Lexington of Wheeling

ID# 0040923

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lexington of Wheeling **#** 0040923 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(123)	0	0	0	0	0	0	0	0	0	0	(123)	2
3	Housekeeping	0	0	385	0	0	0	0	0	0	0	0	385	3
4	Laundry	(2,756)	0	0	0	0	0	0	0	0	0	0	(2,756)	4
5	Heat and Other Utilities	0	0	3,858	0	0	0	0	0	0	0	0	3,858	5
6	Maintenance	0	0	2,455	0	0	0	0	0	0	0	0	2,455	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,879)	0	6,698	0	0	0	0	0	0	0	0	3,819	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(359,586)	0	0	0	0	0	0	0	(359,586)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,595	11,445	0	0	0	0	0	0	0	0	19,040	19
20	Fees, Subscriptions & Promotions	0	0	844	0	0	0	0	0	0	0	0	844	20
21	Clerical & General Office Expenses	0	110	23,915	0	0	0	0	0	0	0	0	24,025	21
22	Employee Benefits & Payroll Taxes	0	0	67,693	0	0	0	0	0	0	0	0	67,693	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,929	0	0	0	0	0	0	0	0	2,929	24
25	Other Admin. Staff Transportation	0	0	0	9,672	0	0	0	0	0	0	0	9,672	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,787	0	0	0	0	0	0	0	3,787	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	7,705	106,826	(346,127)	0	0	0	0	0	0	0	(231,596)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,879)	7,705	113,524	(346,127)	0	0	0	0	0	0	0	(227,777)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Wheeling # 0040923 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	206,195	0	31,562	0	0	0	0	0	0	0	237,757	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,150)	389,119	0	352	0	0	0	0	0	0	0	383,321	32
33	Real Estate Taxes	0	445,705	0	1,898	0	0	0	0	0	0	0	447,603	33
34	Rent-Facility & Grounds	0	(1,645,705)	0	0	0	0	0	0	0	0	0	(1,645,705)	34
35	Rent-Equipment & Vehicles	0	0	0	4,199	0	0	0	0	0	0	0	4,199	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,150)	(604,686)	0	38,011	0	0	0	0	0	0	0	(572,825)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(53,004)	0	0	0	0	0	0	0	0	0	0	(53,004)	43
44	**TOTAL Special Cost Centers**	(53,004)	0	0	0	0	0	0	0	0	0	0	(53,004)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(62,033)	(596,981)	113,524	(308,116)	0	0	0	0	0	0	0	(853,606)	45

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas Discretionary Trust	33.33%	See attached Schedule B		Lexington Health		
John Samatas Discretionary Trust	33.33%			Care Systems of		
Cynthia Thiem Discretionary Trust	33.34%			Wheeling Ltd. Ptsp.	Wheeling	Lessor
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional fee	$	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	$ 7,595	$ 7,595	1
2	V	21	Bank charges		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	110	110	2
3	V	30	Depreciation		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	206,195	206,195	3
4	V	32	Amortization of mortgage costs		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	3,653	3,653	4
5	V	32	Interest expense		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	385,466	385,466	5
6	V	33	Property taxes		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	445,705	445,705	6
7	V	34	Rental expense	1,645,705	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**		(1,645,705)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V		**The owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Lexington Health Care Systems of Wheeling Ltd. Ptsp.						13
14	Total			$ 1,645,705			$ 1,048,724	$ * (596,981)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923
1/1/03-12/31/03

Schedule B

VII. Related Parties
Related Nursing Homes

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 385	$ 385	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	3,789	3,789	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	69	69	17
18	V	6	Repairs & maintenance		Royal Management Corp.	**	2,384	2,384	18
19	V	6	Scavenger & exterminating		Royal Management Corp.	**	71	71	19
20	V	19	Computer consultant & supplies		Royal Management Corp.	**	8,623	8,623	20
21	V	19	Professional fees		Royal Management Corp.	**	2,822	2,822	21
22	V	20	Advertising - help wanted		Royal Management Corp.	**	191	191	22
23	V	20	Dues & subscriptions		Royal Management Corp.	**	653	653	23
24	V	21	Bank charges		Royal Management Corp.	**	3,315	3,315	24
25	V	21	Office supplies & printing		Royal Management Corp.	**	7,572	7,572	25
26	V	21	Postage		Royal Management Corp.	**	3,406	3,406	26
27	V	21	Telephone		Royal Management Corp.	**	9,622	9,622	27
28	V	22	FICA		Royal Management Corp.	**	30,574	30,574	28
29	V	22	FUTA		Royal Management Corp.	**	549	549	29
30	V	22	SUTA		Royal Management Corp.	**	951	951	30
31	V	22	Insurance - W/C		Royal Management Corp.	**	579	579	31
32	V	22	Insurance - hospitalization		Royal Management Corp.	**	30,216	30,216	32
33	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	4,824	4,824	33
34	V	24	Travel & seminar		Royal Management Corp.	**	2,929	2,929	34
35	V								35
36	V								36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 113,524	$ * 113,524	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 9,672	$ 9,672	15
16	V	26	Insurance general		Royal Management Corp.	**	3,787	3,787	16
17	V	30	Depreciation - vehicles		Royal Management Corp.	**	3,355	3,355	17
18	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	7,843	7,843	18
19	V	30	Depreciation - equipment		Royal Management Corp.	**	20,364	20,364	19
20	V	32	Interest		Royal Management Corp.	**	352	352	20
21	V	33	Property taxes		Royal Management Corp.	**	1,898	1,898	21
22	V	35	Equipment rental		Royal Management Corp.	**	4,199	4,199	22
23	V	17	Management fees	359,586	Royal Management Corp.	**		(359,586)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V		**Certain owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Royal Management Corp.						37
38	V								38
39	Total			$ 359,586			$ 51,470	$ * (308,116)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	4	8%	Salary	$ 34,993	L17, C1	1
2	John Samatas	Owner/Offier	Admin/Plant Ops	33.33%	See Schedule C	3	6%	Salary	21,870	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	1	3%	Salary	17,496	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	4%	Salary	5,249	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	5	10%	Salary	13,342	L17, C1	5
6											6
7											7
8						All individuals work in excess of 40 hours per week.					8
9											9
10											10
11											11
12											12
13								TOTAL	$ 92,950		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923
1/1/03-12/31/03

ScheduleC

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	17,021	27,234	13,617	4,085	10,383	72,340
Lexington Health Care Center of Chicago Ridge, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Elmhurst, Inc.	14,844	23,751	11,875	3,563	9,055	63,088
Lexington Health Care Center of LaGrange, Inc.	10,787	17,259	8,629	2,589	6,580	45,844
Lexington Health Care Center of Lake Zurich, Inc.	20,089	32,143	16,071	4,821	12,254	85,378
Lexington Health Care Center of Lombard, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Orland Park, Inc.	26,721	42,748	21,376	6,413	16,298	113,556
Lexington Health Care Center of Schaumburg, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Lexington Health Care Center of Streamwood, Inc.	22,167	35,468	17,734	5,320	13,522	94,211
Total	178,130	285,007	142,504	42,751	108,658	757,050

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	$ 3,521	$	80,665	$ 385	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	34,652		80,665	3,789	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	635		80,665	69	3
4	6	Repairs & maintenance	Bed Days	737,665	10	21,802		80,665	2,384	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	648		80,665	71	5
6	19	Computer consultant & supplies	Bed Days	737,665	10	78,852		80,665	8,623	6
7	19	Professional fees	Bed Days	737,665	10	25,806		80,665	2,822	7
8	20	Advertising - help wanted	Bed Days	737,665	10	1,748		80,665	191	8
9	20	Dues & subscriptions	Bed Days	737,665	10	5,976		80,665	653	9
10	21	Bank charges	Bed Days	737,665	10	30,319		80,665	3,315	10
11	21	Office supplies & printing	Bed Days	737,665	10	69,243		80,665	7,572	11
12	21	Postage	Bed Days	737,665	10	31,145		80,665	3,406	12
13	21	Telephone	Bed Days	737,665	10	87,995		80,665	9,622	13
14	22	FICA	Bed Days	737,665	10	279,595		80,665	30,574	14
15	22	FUTA	Bed Days	737,665	10	5,021		80,665	549	15
16	22	SUTA	Bed Days	737,665	10	8,695		80,665	951	16
17	22	Insurance - W/C	Bed Days	737,665	10	5,294		80,665	579	17
18	22	Insurance - hospitalization	Bed Days	737,665	10	276,319		80,665	30,216	18
19	22	401(k) and other emp. benefits	Bed Days	737,665	10	44,113		80,665	4,824	19
20	24	Travel & seminar	Bed Days	737,665	10	26,781		80,665	2,929	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,038,160	$		$ 113,524	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	$ 88,444	$	80,665	$ 9,672	1
2	26	Insurance general	Bed Days	737,665	10	34,634		80,665	3,787	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	30,679		80,665	3,355	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	71,727		80,665	7,843	4
5	30	Depreciation - equipment	Bed Days	737,665	10	186,226		80,665	20,364	5
6	32	Interest	Bed Days	737,665	10	3,219		80,665	352	6
7	33	Property taxes	Bed Days	737,665	10	17,360		80,665	1,898	7
8	35	Equipment rental	Bed Days	737,665	10	38,401		80,665	4,199	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 470,690	$		$ 51,470	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial						$	$			$	1
2	Services II, L.L.C.	X		Mortgage	$49,514.00	12/29/98	6,513,000	5,614,278	12/29/08	0.0675	385,466	2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	X		Working Capital	None	Various	675,000	642,356	Demand	0.0425	6,021	6
7	LaSalle Bank, N.A.		X	Line of Credit	Various	12/01/02	1,000,000		11/30/04	Prime	10,141	7
8												8
9	TOTAL Facility Related				$49,514.00		$ 8,188,000	$ 6,256,634			$ 401,628	9
	B. Non-Facility Related*											
10								Amortization of loan costs			3,653	10
11								Interest income offset			(129)	11
12								Allocated from management company			352	12
13								Nonallowable shareholder interest			(6,021)	13
14	TOTAL Non-Facility Related						$	$			$ (2,145)	14
15	TOTALS (line 9+line14)						$ 8,188,000	$ 6,256,634			$ 399,483	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.		$ 396,000	1
	Allocated from Management Company	1,898	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	$ 410,289	2
3. Under or (over) accrual (line 2 minus line 1).		$ 16,187	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 432,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 7,346	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$ (584)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 454,949	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	365,183	8
	1999	373,589	9
	2000	379,331	10
	2001	379,253	11
	2002	410,289	12

2002 taxes:	410,289
Estimated increase:	1.05
Estimated 2003 taxes:	430,803
Use:	432,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Wheeling COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040923

CONTACT PERSON REGARDING THIS REPORT Ms. Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4700

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-10-401-027-0000	Land & Building	$ 410,289.00	$ 410,289.00
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-019	Land & Building	$ 212,239.00	$ 4,316.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 622,528.00	$ 414,605.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,551 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	137,650	1993	$ 595,000	1
2	Mgmt Co.		2002	17,446	2
3	TOTALS	137,650		$ 612,446	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	211		1995	1995	$ 6,537,447	$	10-40	$ 164,075	$ 164,075	$ 1,415,150	4
5	10		2000	2000	98,710	2,468	40	2,468		8,637	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvement			1995	3,587		15	239	239	2,063	9
10	Land improvement - sidewalk replacemen			1996	1,927	128	15	128		962	10
11	Leasehold improvement - pines & sod			1996	3,432	229	15	229		1,716	11
12	Basement rehab			1997	18,611	1,861	10	1,861		12,097	12
13	Building improvement - curtains/track			1997	1,936		35	55	55	359	13
14	Landscaping			1997	2,002	134	15	134		868	14
15	Wiring for MDS			1998	3,552	355	10	355		1,953	15
16	Parking Lot			1998	2,952	295	10	295		1,624	16
17	Roof repair			2000	1,980	198	10	198		693	17
18	Remodel HVAC/exhaust system - office area			2000	7,480	374	20	374		1,309	18
19	Automatic Door			2000	1,300	130	10	130		455	19
20	Rods for beside curtains			2000	2,525	252	10	252		884	20
21	Floor tile			2000	10,298	1,030	10	1,030		3,604	21
22	Parking lot seal coating and repair			2001	2,177	218	10	218		544	22
23	Infrared curtain units for 3 elevators			2001	4,500	900	5	900		2,250	23
24	Boiler vent repairs			2001	3,084	308	10	308		770	24
25	Kitchen wall rebuild			2003	22,500	375	20	375		375	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Leasehold improvements - management company	1995	$ 11,058	$	35	$ 328	$ 328	$ 2,685	37
38	Leasehold improvements - management company	1996	8,999		35	267	267	1,928	38
39	Leasehold improvements - management company	1989	310		31	9	9	155	39
40	HVAC - management company	1998	233		35	7	7	40	40
41	Offices - management company	1999	588		35	17	17	76	41
42	Land improvements - management company	2002	27,497		15	815	815	3,513	42
43	Building - management company	2002	213,924		40	6,329	6,329	10,251	43
44	HVAC, electrical, security system - management company	2003	2,120		30	54	54	54	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,994,729	$ 9,255		$ 181,450	$ 172,195	$ 1,475,015	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 564,641	$ 21,757	$ 63,583	$ 41,826	5-10 yrs	$ 461,988	71
72	Current Year Purchases	33,371	1,464	1,464		3-10 yrs	1,464	72
73	Fully Depreciated Assets							73
74	Allocated from management company	195,810		20,364	20,364		64,893	74
75	TOTALS	$ 793,822	$ 23,221	$ 85,411	$ 62,190		$ 528,345	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from management company			32,720		335	335		26,124	79
80	TOTALS			$ 32,720	$	$ 335	$ 335		$ 26,124	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,433,717	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,476	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 267,196	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 234,720	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,029,484	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 7,420 Description: Copier $3,221 $; Allocated from management - $4,199
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	4,285	$ 263,802	$	4,285	$ 263,802	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		698	40,459		698	40,459	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		6,355	295,343		6,355	295,343	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				123,924		123,924	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Wound therapy	L10A, C3				562			562	13
14	TOTAL			$	11,338	$ 600,166	$ 123,924	11,338	$ 724,090	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 170,369	$ 187,651	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 632,868)	1,290,653	1,290,653	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,972	4,972	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	50,640	50,640	8
9	Other(specify): Escrow		157,954	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,516,634	$ 1,691,870	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,612	8,612	12
13	Land		612,446	13
14	Buildings, at Historical Cost		6,528,926	14
15	Leasehold Improvements, at Historical Cost	187,030	465,803	15
16	Equipment, at Historical Cost	179,749	826,542	16
17	Accumulated Depreciation (book methods)	(148,680)	(2,029,484)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized mortgage costs		54,790	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 226,711	$ 6,467,635	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,743,345	$ 8,159,505	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 492,231	$ 492,231	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	642,356	642,356	29
30	Accrued Salaries Payable	259,257	259,257	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,605	2,605	31
32	Accrued Real Estate Taxes(Sch.IX-B)		432,000	32
33	Accrued Interest Payable		31,580	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	1,025,466	79,964	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,421,915	$ 1,939,993	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,614,278	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,614,278	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,421,915	$ 7,554,271	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (678,570)	$ 605,234	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,743,345	$ 8,159,505	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923
1/1/03-12/31/03

Schedule E

XV. Balance Sheet

C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued Rent	945,502	
Accrued management fees	27,900	27,900
Accrued 401 (k) contribution	16,835	16,835
Other accrued expenses	35,229	35,229
Total line 36	1,025,466	79,964

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Miscellaneous Income	110
Investment Income in Lexington Financial Services, LLC	484
Total line 28	594

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 693,783	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 693,783	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,372,353)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,372,353)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (678,570)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,675,582	1
2	Discounts and Allowances for all Levels	(513,091)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,162,491	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,010,760	6
7	Oxygen	630	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,011,390	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,561	12
13	Barber and Beauty Care	27,089	13
14	Non-Patient Meals	123	14
15	Telephone, Television and Radio	5	15
16	Rental of Facility Space		16
17	Sale of Drugs	182,664	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,144	19
20	Radiology and X-Ray	3,125	20
21	Other Medical Services	35,255	21
22	Laundry	2,756	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 265,722	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	129	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 129	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule E**	594	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 594	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,440,326	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,318,921	31
32	Health Care	4,388,594	32
33	General Administration	2,081,516	33
	B. Capital Expense		
34	Ownership	1,694,527	34
	C. Ancillary Expense		
35	Special Cost Centers	208,124	35
36	Provider Participation Fee	120,997	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,812,679	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,372,353)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,372,353)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity files a cash basis tax return.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,226	2,387	$ 88,540	$ 37.09	1
2	Assistant Director of Nursing	4,054	4,224	118,612	28.08	2
3	Registered Nurses	50,627	55,176	1,541,409	27.94	3
4	Licensed Practical Nurses	4,765	5,380	126,499	23.51	4
5	Nurse Aides & Orderlies	96,383	102,441	1,296,940	12.66	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,758	6,294	76,640	12.18	8
9	Activity Director	1,832	2,000	28,849	14.42	9
10	Activity Assistants	14,473	15,273	146,022	9.56	10
11	Social Service Workers	3,255	3,514	58,013	16.51	11
12	Dietician	1,956	2,114	32,005	15.14	12
13	Food Service Supervisor	2,045	2,147	32,237	15.01	13
14	Head Cook	1,352	1,511	15,034	9.95	14
15	Cook Helpers/Assistants	12,022	12,853	98,625	7.67	15
16	Dishwashers	16,648	17,307	107,653	6.22	16
17	Maintenance Workers	3,882	4,367	70,203	16.08	17
18	Housekeepers	36,751	39,237	262,003	6.68	18
19	Laundry	9,305	10,002	64,345	6.43	19
20	Administrator	1,583	1,892	75,325	39.81	20
21	Assistant Administrator					21
22	Other Administrative	705	709	92,950	131.10	22
23	Office Manager					23
24	Clerical	22,698	26,634	530,564	19.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	292,320	315,462	$ 4,862,468 *	$ 15.41	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	237	$ 11,224	L1, C3	35
36	Medical Director	12	24,000	L9, C3	36
37	Medical Records Consultant	19	950	L10, C3	37
38	Nurse Consultant	47	1,406	L10, C3	38
39	Pharmacist Consultant	12	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	141	6,709	L11, C3	44
45	Social Service Consultant	48	2,202	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	516	$ 47,691		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,594	$ 31,882	L10, C3	50
51	Licensed Practical Nurses	129	2,321	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,723	$ 34,203		53

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James Samatas	Administrative	33.33%	$ 34,993
John Samatas	Admin/Plant Ops	33.33%	21,870
Cynthia Thiem	Administrative	33.34%	17,496
George Samatas	Administrative	0.00%	5,249
Jason Samatas	Administrative	0.00%	13,342
See attached Schedule F1			75,325
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 168,275

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 359,586
TOTAL (agree to Schedule V, line 17, col. 3)	$ 359,586
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin & Glasser, LLP	Accounting	$ 15,139
American Express Tax & Bus. Svs.	Accounting	5,510
Freedman, Anselmo & Lindberg	Collections	12,039
Global Care	Consulting	945
Harris, Kessler & Goldstein	Legal	1,039
ING	401(k) Administration	585
James Samatas	Legal	50
Personnel Planners	U/C Consulting	1,245
Sachnoff and Weaver	Legal	9,740
Grabowski & Green	Collections	542
See attached Schedule F2		12,969
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 59,803

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,178
Unemployment Compensation Insurance	72,408
FICA Taxes	348,301
Employee Health Insurance	254,715
Employee Meals	12,429
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	19,592
Other employee benefits	5,888
TOTAL (agree to Schedule V, line 22, col.8)	$ 746,511

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	37,008
Health Care Worker Background Check	
(Indicate # of checks performed)	
Miscellaneous Dues & Subs	1,187
Miscellaneous Licenses & Permits	691
Allocated from management company	844
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,730

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,836
Allocated from management company	2,929
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,765

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923
1/1/03-12/31/03

Schedule F1

XIX. Support Schedules
A. Administrative Salaries

Name	Function	Ownership	Amount
Richard Curtis	Administrator	0.00%	8,289
Anne Donos	Administrator	0.00%	58,096
Lynn Ryan	Administrator	0.00%	8,940
Total			75,325

See Accountants' Compilation Report

Lexington Health Care Center of Wheeling, Inc.
Provider # 0040923
1/1/03-12/31/03

Schedule F2

XIX. Support Schedules
C. Professional Services

Vendor/Payee		Type	Amount
	Katten, Muchin, Zavis and Rosenman	Legal	4,645
	Carol Jescke	Staffing consultant	847
	Gilson, Labus & Silverman	Accounting	76
	Nyemaster, Goode, Voigts, West, Hansell & O'Brien	Legal	850
	Telenet Communications	Computer consulting	251
	Advanced Answers on Demand, Inc.	Computer consulting	2,652
	Information Control, Inc.	Computer consulting	1,156
	Gigatrend	Computer consulting	195
	Action Computer Services	Computer consulting	346
	Administar	Computer consulting	378
	KraKau Business	Computer consulting	493
	eHealth Solutions	Computer consulting	1,080
			12,969
Total, Agrees to Schedule V, Line 19, Column 3			59,803
Allocated from management co.			
	American Express Tax & Business Services	Accounting	615
	Gilson, Labus and Silverman	Accounting	56
	James Samatas	Legal	76
	Katten, Muchin, Zavis and Rosenman	Legal	72
	Sachnoff and Weaver	Legal	559
	Personnel Planners	U/C Consulting	26
	ING / Pension Administrators	401 (k) Administration	753
	Various	Consulting	664
	Various	Computer Consulting	8,623
Allocated from building partnership			
	James Samatas	Filing and recording fees	250
	McCracken, Walsh, de Lavan	Real estate tax appeal fees	7,346
Reclassifications			
	McCracken, Walsh, de Lavan	Real estate tax appeal fees	(7,346)
Nonallowable legal fees			
	Freedman, Anselmo, & Lindberg	Legal-collection fees	(283)
	Grabowski & Green	Collection fees	(542)
	Katten, Muchin, Zavis and Rosenman	Legal-out of period fees	(286)
	Various	Collection fees	(11,756)
Total, Agrees to Schedule V, Line 19, Column 8			58,630

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4							N/A						
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 01/01/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **58,835** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **120,997**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **12,429** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **123**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Lexington of Wheeling** **12:23 PM 11/4/2005**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS		COMPARE C	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-872,672	equal to	-872,672	0	O.K.		Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	399,483	equal to	399,483	0	O.K.		Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	454,949	equal to	454,949	0	O.K.		Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!		Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	267,196	equal to	267,196	0	O.K.		Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.		Pg14 L20+N:	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	7,420	equal to	7,420	0	O.K.		Pg14 J30+N	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.		Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.		Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	599,604	equal to	600,166	-562	FAILED	ok, wound therapy on sch D for $562	Pg16 Z12+Z1	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	123,924	equal to	#VALUE!	#VALUE!	#VALUE!		Pg16 V32	N/A	14	6	Pg4 F22 + P:	N/A	39,10a	2
Income Stat. General Serv.	1,318,921	equal to	1,318,921	0	O.K.		Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,388,594	equal to	4,388,594	0	O.K.		Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstatior	2,081,516	equal to	2,081,516	0	O.K.		Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,694,527	equal to	1,694,527	0	O.K.		Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	208,124	equal to	208,124	0	O.K.		Pg19 P17	N/A	35	2	Pg4 H21..H2	N/A	38to41+43	4
Income Stat. Prov. Partic.	120,997	equal to	120,997	0	O.K.		Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,172,000	equal to	3,248,640	-76,640	FAILED	ok rehab aides	Pg20 K11..K1	A.	5,24,25,27-:	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.		Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.		Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	174,871	equal to	174,871	0	O.K.		Pg20 K19+K2	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	58,013	equal to	58,013	0	O.K.		Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	285,554	equal to	285,554	0	O.K.		Pg20 K22..K	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	70,203	equal to	70,203	0	O.K.		Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	262,003	equal to	262,003	0	O.K.		Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	64,345	equal to	64,345	0	O.K.		Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	168,275	equal to	168,275	0	O.K.		Pg20 K30..K:	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	530,564	equal to	530,564	0	O.K.		Pg20 K33..K:	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.		Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	4,862,468	equal to	4,862,468	0	O.K.		Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	11,224	< or = to	11,224	0	O.K.		Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	24,000	< or = to	24,000	0	O.K.		Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	37,759	< or = to	74,691	-36,932	O.K.	ok oxygen, medical equip	Pg20 X14..X	B. & C.	o39 and 50t	2	Pg3 G19	N/A	10	3
Activity Consultant	6,709	< or = to	6,709	0	O.K.		Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,202	< or = to	2,202	0	O.K.		Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	168,275	equal to	168,275	0	O.K.		Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	359,586	equal to	359,586	0	O.K.		Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	59,803	equal to	59,803	0	O.K.		Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Professional Fees - pg. 3 column 8/Sch	58,630	equal to	58,630	0	O.K.									
Supp. Sched.- Benefit/Taxes	746,511	equal to	746,511	0	O.K.		Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	39,730	equal to	39,730	0	O.K.		Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,765	equal to	6,765	0	O.K.		Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	120,997	equal to	120,997	0	O.K.		Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	12,429	< or = to	80,120	-67,691	O.K.		Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	12,429	equal to	12,429	0	O.K.		Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.		Pg15 U29..U	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	4,597	equal to	6,989	-2,392	FAILED	ok, medicare days $4,597	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-791,573	equal to	-791,573	0	O.K.		Pg5 Z18	B.	34	1	Pg6 to Pg 6I	B.	14	8
Total loan balance	6,256,634	equal to	6,256,634	0	O.K.		Pg9 L34	A.	15	7	Pg17 V13+V2	N/A	29+39-41	2
Real estate tax accrual	432,000	equal to	432,000	0	O.K.		Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	612,446	equal to	612,446	0	O.K.		Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	6,994,729	equal to	6,994,729	0	O.K.		Pg12 to 12I	B.	36	4	Pg17 K26+K2	N/A	14 & 15	2
Equipment and vehicle cost	826,542	equal to	826,542	0	O.K.		Pg13 O22+L:	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,029,484	equal to	2,029,484	0	O.K.		Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-678,570	equal to	-678,570	0	O.K.		Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-1,372,353	equal to	-1,372,353	0	O.K.		Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.		Pg22 F31-J3	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,743,345	equal to	1,743,345	0	O.K.		Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK TO THE COST REPORT!!**			11/4/2005	12:23:11 PM		
HSA Number	?	Name		Lexington of Wheeling			
Cost report period	From:	01/01/03	To:	12/31/03		Base Number	336
If this is an ICF/DD 16 facility, enter a 1 in cell C		N					
Licensed bed days:	80,665	Occupancy:		60,221	Pct. of occupancy:	74.66%	
Illinois Public Aid Support Rate				$			
Genl Services Salary/Wage:	682,105	Col 1, Line 8 ---Audit Adj:					
Genl Admin Salary/Wage	698,839	Col 1, Line 28 ---Audit Adj:					
Total Salary Wage	4,862,468	Col 1, Line 44 ---Audit Adj:					
Employee Benefits	746,511	Col 8, Line 22 ---Audit Adj:					
Total General Services:	1,310,312	Col 8, Line 8 ---Audit Adj:					
Total General Admin	1,842,024	Col 8, Line 28 ---Audit Adj:					

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$682,105
Divided by Total Wages (Column 1, Line 44	$4,862,468
General service wages as percent of total wages	14.0280%
Employee Benefits (Column 10, Line 22	$746,511
Allocation of Employee Benefits to General Services Costs	$104,721
Plus Total General Services (Column 10, Line 8	$1,310,312
New Total General Services Cost	$1,415,033

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by the proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your total General Administration expenses

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$698,839
Divided by Total Wages (Column 1, Line 45	$4,862,468
General administration wages as a percent of total wages	14.3721%
Employee Benefits (Column 10, Line 22	$746,511
Allocation of Employee Benefits to General Admin. Cost	$107,289
Plus Total General Administration (Column 10, Line 2	$1,842,024
Minus Total Fringe (Column 10, Line 2	$746,511
New Total General Administration Cos	$1,202,802

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206	multiplied by 6 =	1236
Sum of the three lines			1243.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			336

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$1,415,033	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$1,415,033

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$1,202,802	
General Administration Multiplier (Step II-E	1	
Updated General Services Cost		$1,202,802
3 Total Updated Support Costs (1 + 2		$2,617,835

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $40.18

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$2,617,835
Total Patient Days (Cost Report	60,221
Support Costs per Diem	$43.47

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	80,665
Multiplied by	0.93
	75,018
Minus total Patient Days	60,221
	14,797
One-third of difference	4,932
Plus Total Patient Day	60,221
Adjusted Occupancy	65,153
Total Support Costs (Step II, C, 3, above	$2,617,835
Divided by Adjusted Occupany	65153
Support Costs Per Diem	$40.18

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Dier	$40.18
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Plus Support Costs Per Dier	$40.18
Support Rate if costs are between 35th and 75th percentile	#N/A

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	#N/A
Minus Support Costs Per Dier	$40.18
Difference	#N/A
Multiply the Difference by	0.5
One-Half of the Difference	#N/A
Compare one-half the difference to the profit ceiling for your HSA in Table II and	#N/A
Enter the Lower of the Two Amounts	#N/A
Plus Support Costs Per Dier	$40.18
Support Rate if support costs less than 35th percentile	#N/A

D. **YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abo** **#N/A**

75th Percentile is	#N/A
35th Percentile is	#N/A

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/4/2005 12:23:11 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Lexington of Wheeling** ID: **0040923**

HSA No.: ? Own or Rent? (O or R): ______ Own or Rent Beginning: ______

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): N
or since the first day of operation for buildings constructed since January 1, 1978?

Cost Report Pd:		Licensed Beds:	221	Total Patient Days	60,221
Begin	**01/01/03**	Licensed Bed Days:	80,665	% Occupied	74.66%
End	**12/31/03**			Capital Days	75,018

1989 Property Tax COST: ______ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ______ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ______ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1995
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	6994729
2. Total licensed beds from cost report Page 2, Line 7, column 3	221
3. Line 1 divided by Line 2	$31,650
4. Regional construction inflator from Table 2	#N/A
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#N/A
C. Obtain the Uniform Building Value from Table 1	#VALUE!
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	#N/A
2. Uniform building value from Line C	#VALUE!
3. Add Lines 1 and 2	#VALUE!
4. Divide by 2 to obtain average	#VALUE!
5. Enter 120% of line C	#VALUE!
6. The blended value is the lesser of Line 4 or Line 5	#VALUE!
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#VALUE!
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#VALUE!
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	#VALUE!
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	75,018
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A
5. Equals: Updated Property Tax Cost	#N/A

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	60,221
2. Total Licensed Bed Days * .93	75018
3. Capital Days (higher of Line 1 or Line 2)	75,018

K. Total Capital Rate for FY 94

1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#VALUE!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#VALUE!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	95	6537447	621057465	12
2	2	100	98710	9871000	12
3	3	0	0	0	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	95	3587	340765	12
7	7	96	1927	184992	12
8	8	96	3432	329472	12
9	9	97	18611	1805267	12
10	10	97	1936	187792	12
11	11	97	2002	194194	12
12	12	98	3552	348096	12
13	13	98	2952	289296	12
14	14	100	1980	198000	12
15	15	100	7480	748000	12
16	16	100	1300	130000	12
17	17	100	2525	252500	12
18	18	100	10298	1029800	12
19	19	101	2177	219877	12
20	20	101	4500	454500	12
21	21	101	3084	311484	12
22	22	103	22500	2317500	12
23	23	0	0	0	12
24	24	0	0	0	12
25	25	0	0	0	12
26	26	0	0	0	12
27	27	0	0	0	12
28	28	0	0	0	12
29	29	0	0	0	12
30	30	0	0	0	12
31	31	0	0	0	12
32	32	0	0	0	12
33	33	0	0	0	12
34	34	95	11058	1050510	12A
35	35	96	8999	863904	12A
36	36	89	310	27590	12A
37	37	98	233	22834	12A
38	38	99	588	58212	12A
39	39	102	27497	2804694	12A
40	40	102	213924	21820248	12A
41	41	103	2120	218360	12A
42	42	0	0	0	12A
43	43	0	0	0	12A
44	44	0	0	0	12A
45	45	0	0	0	12A
46	46	0	0	0	12A
47	47	0	0	0	12A
48	48	0	0	0	12A
49	49	0	0	0	12A
50	50	0	0	0	12A
51	51	0	0	0	12A
52	52	0	0	0	12A
53	53	0	0	0	12A
54	54	0	0	0	12A
55	55	0	0	0	12A
56	56	0	0	0	12A
57	57	0	0	0	12A
58	58	0	0	0	12A
59	59	0	0	0	12A
60	60	0	0	0	12A
61	61	0	0	0	12A
62	62	0	0	0	12A
63	63	0	0	0	12A
64	64	0	0	0	12A
65	65	0	0	0	12A
66	66	0	0	0	12A
67	67	0	0	0	12B
68	68	0	0	0	12B
69	69	0	0	0	12B
70	70	0	0	0	12B
71	71	0	0	0	12B
72	72	0	0	0	12B
73	73	0	0	0	12B
74	74	0	0	0	12B
75	75	0	0	0	12B
76	76	0	0	0	12B
77	77	0	0	0	12B
78	78	0	0	0	12B
79	79	0	0	0	12B
80	80	0	0	0	12B
81	81	0	0	0	12B
82	82	0	0	0	12B
83	83	0	0	0	12B
84	84	0	0	0	12B
85	85	0	0	0	12B
86	86	0	0	0	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
135	0	0	0	12D
136	0	0	0	12D
137	0	0	0	12D
138	0	0	0	12D
139	0	0	0	12D
140	0	0	0	12D
141	0	0	0	12D
142	0	0	0	12D
143	0	0	0	12D
144	0	0	0	12D
145	0	0	0	12D
146	0	0	0	12D
147	0	0	0	12D
148	0	0	0	12D
149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

667136352 6994729 95.37701203

Base Year = 1995

TABLE 1 error

Table 1 Uniform building Value

	Uniform Building Value	
Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	285,554	42,999	11,224	339,777	0	339,777	0	339,777
2. Food Purchase	0	272,104	0	272,104	0	272,104	-12,552	259,552
3. Housekeeping	262,003	33,061	0	295,064	0	295,064	385	295,449
4. Laundry	64,345	19,309	0	83,654	0	83,654	-2,756	80,898
5. Heat and Other Utilities	0	0	150,611	150,611	0	150,611	3,859	154,470
6. Maintenance	70,203	0	107,508	177,711	0	177,711	2,455	180,166
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	682,105	367,473	269,343	1,318,921	0	1,318,921	-8,609	1,310,312
9. Medical Director	0	0	24,000	24,000	0	24,000	0	24,000
10. Nursing & Medical Records	3,248,640	185,437	74,691	3,508,768	0	3,508,768	0	3,508,768
10a. Therapy	0	0	600,166	600,166	0	600,166	0	600,166
11. Activities	174,871	13,865	6,709	195,445	0	195,445	0	195,445
12. Social Services	58,013	0	2,202	60,215	0	60,215	0	60,215
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,481,524	199,302	707,768	4,388,594	0	4,388,594	0	4,388,594
17. Administrative	168,275	0	359,586	527,861	0	527,861	-359,586	168,275
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	59,803	59,803	0	59,803	-1,173	58,630
20. Fees, Subscriptions & Promotion	0	0	38,886	38,886	0	38,886	844	39,730
21. Clerical & General Office	530,564	36,651	22,699	589,914	0	589,914	23,915	613,829
22. Employee Benefits & Payroll	0	0	666,391	666,391	0	666,391	80,120	746,511
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	3,836	3,836	0	3,836	2,929	6,765
25. Other Admin. Staff Trans	0	0	0	0	0	0	9,672	9,672
26. Insurance-Prop.Liab.Malpractice	0	0	194,825	194,825	0	194,825	3,787	198,612
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	698,839	36,651	1,346,026	2,081,516	0	2,081,516	-239,492	1,842,024
29. Total General Administrative	4,862,468	603,426	2,323,137	7,789,031	0	7,789,031	-248,101	7,540,930
30. Depreciation	0	0	29,439	29,439	0	29,439	237,757	267,196
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	16,162	16,162	0	16,162	383,321	399,483
33. Real Estate	0	0	0	0	0	0	454,949	454,949
34. Rent - Facility & Grounds	0	0	1,645,705	1,645,705	0	1,645,705	-1,645,705	0
35. Rent - Equipment & Vehicles	0	0	3,221	3,221	0	3,221	4,199	7,420
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	1,694,527	1,694,527	0	1,694,527	-565,479	1,129,048
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	123,924	0	123,924	0	123,924	0	123,924
40. Barber and Beauty Shop	0	0	23,462	23,462	0	23,462	0	23,462
41. Coffee and Gift Shops	0	0	1,646	1,646	0	1,646	0	1,646
42. Provider Participation	0	0	120,997	120,997	0	120,997	0	120,997
43. Other (specify):*	0	0	59,092	59,092	0	59,092	-59,092	0
44. Total Special Cost Ce	0	123,924	205,197	329,121	0	329,121	-59,092	270,029
45. Grand Total	4,862,468	727,350	4,222,861	9,812,679	0	9,812,679	-872,672	8,940,007

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	170,369	187,651
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,290,653	1,290,653
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	4,972	4,972
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	50,640	50,640
9. Other (specify):	0	157,954
10. Total current assets	1,516,634	1,691,870
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	8,612	8,612
13. Land	0	612,446
14. Buildings, at Historical Cost	0	6,528,926
15. Leasehold Improvements, Historical Cost	187,030	465,803
16. Equipment, at Historical Cost	179,749	826,542
17. Accumulated Depreciation (book methods)	-148,680	-2,029,484
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	54,790
24. Total Long-Term Assets	226,711	6,467,635
25. Total Assets	1,743,345	8,159,505
CURRENT LIABILITIES		
26. Accounts Payable	492,231	492,231
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	642,356	642,356
30. Accrued Salaries Payable	259,257	259,257
31. Accrued Taxes Payable	2,605	2,605
32. Accrued Real Estate Taxes	0	432,000
33. Accrued Interest Payable	0	31,580
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	1,025,466	79,964
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	2,421,915	1,939,993
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	5,614,278
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	5,614,278
46.Total Liabilities	2,421,915	7,554,271
47.Total Equity	-678,570	605,234
48.Total Liabilities and Equity	1,743,345	8,159,505

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	7,675,582
2. Discounts and Allowances for all Levels	-513,091
Subtotal - Inpatient Care	7,162,491
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,010,760
7. Oxygen	630
Subtotal - Anciliary Revenue	1,011,390
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	2,561
13. Barber and Beauty Care	27,089
14. Non-Patient Meals	123
15. Telephone, Television, and Radio	5
16. Rental of Facility Space	0
17. Sale of Drugs	182,664
18. Sale of Supplies to Non-Patients	0
19. Laboratory	12,144
20. Radiologyand X-Ray	3,125
21. Other Medical Services	35,255
22. Laundry	2,756
Subtotal - Other Operating Revenue	265,722
24. Contributions	0
25. Interest and Other Investments Income	129
Subtotal - Non-Operating Revenue	129
27. Other Revenue (specify):	594
28. Other Revenue (specify):	0
Subtotal - Other Revenue	594
30. Total Revenue	8,440,326
31. General Services	1,318,921
32. Health Care	4,388,594
33. General Administration	2,081,516
34. Ownership	1,694,527
35. Special Cost Centers	208,124
35. Provider Participation Fee	120,997
37. Other	0
40. Total Expenses	9,812,679
41. Income Before Income Taxes	-1,372,353
42. Income Taxes	0
43. Net Income or Loss for the Year	-1,372,353

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23	Provider Participation fee is linked from page 4